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ABSTRACT

The major results of a World Health Organization consultation meeting which was organized to examine ways and means of improving the status of substance abuse education for health professionals in some European countries is presented. Conference participants included researchers, psychiatrists, advisers, clinicians, health administrators, and experts from 10 European countries and the United States involved in the design and implementation of substance abuse courses in the curricula of medical schools both at the postgraduate and undergraduate level. The report discusses several important aspects: (1) substance abuse problems in the European region including Austria, France, Spain, Sweden and the Soviet Union; (2) differences among national substance abuse policies in the European region; (3) substance abuse education in the United States; (4) the objectives of substance abuse training; (5) training methods; (6) structural conditions for the implementation of training programmes; and (7) postgraduate training programmes. A number of general and specific recommendations are provided for undergraduate and postgraduate training programmes. Specific guidelines for the training of general practitioners and general psychiatrists, and for implementing programmes for disciplines specifically related to substance abuse problems are outlined together with recommendations for training nonmedical health professionals. Participants, and their addresses and affiliations, are listed. (LPT)

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SUBSTANCE-ABUSE EDUCATION FOR HEALTH PROFESSIONALS

Report on a WHO Consultation

Vienna
20-22 May 1987

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TARGET 15

Knowledge and motivation for healthy behaviour

By 1990, educational programmes in all Member States should enhance the knowledge, motivation and skills of people to acquire and maintain health.

Index:

SUBSTANCE ABUSE
HEALTH OCCUPATIONS %ED%
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1. Introduction

In 1985, the Regional Office for Europe of the World Health Organization held an enquiry into substance abuse education for health professionals in a selected number of countries in the Region. The enquiry took place within the framework of the Organization's programme on the abuse of psychoactive drugs. One of the main conclusions was that while in a small number of countries some good, if somewhat uncoordinated, efforts are being developed, there is no, or very little, specific training on these problems available in most other countries. This is of serious concern in view of the growing prevalence of alcohol and drug problems which makes it extremely likely that the health professional will encounter many such problems in his daily practice.

In order to study ways and means of improving this situation a consultation was organized by the WHO Regional Office for Europe in Vienna from 20 to 22 May 1987. Taking the 1985 enquiry as its starting point and building on work already carried out in this area by the Mental Health Division of WHO headquarters in Geneva, this meeting focused especially on substance abuse education in medical schools.

The Meeting brought together a group of experts from ten European countries and the United States who are involved in the design and implementation of substance abuse courses in the curricula of medical schools, either at undergraduate or postgraduate level. In their discussions they concentrated on the following specific areas:

- a review of the situation regarding substance abuse training in medical schools;
- an exchange of experiences on improving the substance abuse training component in overall curricula;
- a review of materials presently being used or under development and identification of gaps and desirable changes;
- advising on ways and means of expanding substance abuse training for health professionals.

This report contains the main results of the discussions, including recommendations on future activities.

2. Background

One of the typical features of the proliferation of substance abuse careers is that it often takes a very long time before there is any serious attempt by a health professional to intervene in the process.

Estimates of the average length between the actual onset of alcohol problems and the first intervention by a health professional vary from five to ten years, or even longer. In general, it is assumed that for drug abusers this period is shorter, because drug abuse is much more of a social taboo and is consequently surrounded by tighter social control which enhances the likelihood of earlier contact with health professionals.

The mere contact between the alcohol or drug abuser and the health professional does not necessarily result in a correct assessment of the substance abuse problem by the health professional. In a recent study by Reid et al., it was found that general practitioners correctly identified only 27.5% of patients who were classified as "high-risk" drinkers (1). Adequate intervention is yet another matter.

Incorrect assessments of the severity of the alcohol or drug problem presented and the subsequent absence of adequate intervention by health professionals reinforce the proliferation of individual problems. A number of constraints separate the physician and the needy patient. In a 1982 American Medical Association poll, for example, 71% of physicians felt either incompetent or ambivalent about treating alcoholism (2). However, patients indicated they would like their physicians to recognize and participate in the treatment of their substance abuse problems. A survey of 316 patients seen in family practice settings found that 90% of the patients felt involvement by physicians was appropriate; 88% welcomed physician assistance with alcohol problems and 95% with other types of drug dependency (3). Although alcohol involvement is evident in from 20% to 50% of general hospital admissions, alcoholism is diagnosed in fewer than 5% of admissions (4).

Negative perceptions of people with substance abuse problems and their chances for successful treatment constitute one of the major obstacles in the willingness to start intensive attempts towards recovery.

Physicians develop most of their negative attitudes towards substance abuse problems in the later stages of their training and afterwards. Many physicians feel they lack self-confidence and competence in dealing with the nonmedical aspects of substance abuse problems. Consequently they tend to refer substance abuse patients rather than treat them themselves. Often they lack appropriate knowledge and skills to make the correct diagnosis and information-processing. They also fail to recognize the chronic nature of most substance abuse problems.

Another barrier is the physicians' opinion about the future recovery chances of an addict. They often believe that people with addiction problems can seldom recover. Many physicians frequently do not have contact with recovered patients in their practices, which may explain this observation.

Education has been shown effective in providing the skills needed to effectively diagnose and treat alcoholics. There is also some evidence that education can produce positive changes in attitudes.

In this context, the health professional may be a social worker in a community health centre, a physician in an emergency department, a community nurse, a psychologist in a community health service, a general practitioner, in fact, any person from whom the public may seek help. Obviously, the family doctor is in a particularly advantageous position to come into contact with substance abuse problems.

The growing prevalence of substance abuse problems makes it extremely likely that health professionals will encounter many such problems in their daily practice. It was estimated that among the 2500 patients in an average practice of a family doctor in the United Kingdom, there are as many as 25-45 alcohol dependents, of whom only 2-7 are known to the general

practitioner (5). Drug abuse problems are less prevalent but nevertheless substantial and very much on the increase in many countries. A recent survey among general practitioners in England and Wales revealed that in the four-week period under review, roughly one in five general practitioners attended an opiate misuser (6).

A closely related issue is the use of psychoactive drugs among practising physicians and medical students. Although reports claim that most of the use among this group is experimental or infrequent, in a recent study from the United States (7), 10% of the physicians who were interviewed reported current regular drug use (once a month or more often) and 3% had histories of drug dependence. A European study found that one out of 16 medical students had used cocaine (8). According to the authors of the American study, "The evidence is clear that warnings against physician drug use in pharmacology textbooks, and medical education that emphasizes the biology of addiction, are not sufficient to prevent physician drug abuse in a drug using society, and that the problem of physician impairment is likely to grow if current patterns of drug use persist" (7).

Another related issue of concern is prescription practices for psychoactive substances. There is a considerable amount of over-prescription of psychoactive drugs. Many publications have dealt with the over-prescription of the benzodizepines. On the other hand, there may be under-prescription of opiates for certain categories of patients, e.g. those in severe pain.

Against this background, it is extremely important that the health professional receives adequate education and training on abuse of psychoactive substances and, more particularly, on the detection and management of substance abuse problems.

3. Proceedings

The Meeting on Substance Abuse Education, convened by the WHO Regional Office for Europe, was held at the Anton Proksch Institute in Vienna from 20 to 22 May 1987. The participants included researchers, psychiatrists, advisers, clinicians and health administrators. The meeting was chaired by Dr Springer, Director of the Ludwig Boltzmann Institut für Suchtforschung in Vienna. Mr W.R. Buisman from the Netherlands was elected rapporteur.

The participants were welcomed by Dr R. Mader, Director of the Anton Proksch Institute. In his address, Dr Mader stressed the importance of the meeting. Current training programmes for physicians and other health professionals were somewhat deficient in quality, because very little attention and time are spent on substance abuse education. Dr Mader referred to an Austrian study, recently conducted among physicians and medical students, which indicated that attitudes towards substance abuse problems were strongly negative. Furthermore, Dr Mader noted that substance abuse problems are ignored not only by physicians and health professionals but also by the general public.

In his welcome address, Dr J. Kurz, representing the Federal Chancellor of Austria, pointed out two major related trends in society: a strong belief in the general public that the solution to diseases lies in more prescription drugs and an increase in the use of psychoactive pharmaceutical substances

such as analgesics and illicit drugs. According to some recent estimates, about 100 000 people are thought to be dependent on these psychoactive substances.

Dr Kurz claimed that the prescription behaviour of physicians was also responsible for this situation. He stressed the importance of developing a basic curriculum in medical training for the prevention of substance abuse.

Mr C. Goos welcomed the participants on behalf of Dr J.E. Asvall, Regional Director, WHO Regional Office for Europe, and thanked the Anton Proksch Institute for its assistance in hosting the meeting. He reiterated that the overall objective of the Meeting was to encourage substance abuse education in training programmes of health professionals. More specifically, the Meeting should develop an international overview of initiatives, experiences and problems of medical education programmes in substance abuse. Furthermore, the Meeting should provide recommendations on the subject as well as a first opportunity for developing a European support network of organizations dealing with substance abuse education for health professionals.

Mr Goos indicated that efforts aiming at an integration of substance abuse training in education programmes for health professionals would certainly encounter some resistance. Indeed, within the health system there is often major resistance to substance abuse problems. More generally, of course, there is general resistance to any change in existing training programmes.

On the other hand, it is inevitable that sooner or later health professionals will be confronted by substance abuse problems in different phases in their daily practice and therefore insufficient training on this subject is intolerable. Mr Goos went on to refer to the WHO goal of achieving health for all by the year 2000, in which high priority is given to the prevention of substance abuse problems. The European Region had adopted a common, detailed health for all policy in the document "Targets for health for all". He also referred to the work already done by the headquarters programme on this subject. Amongst other activities, a manual on substance abuse education has been prepared and is expected to be published soon.

4. Substance abuse problems in the European Region

One of the first initiatives of the Regional Office in the area of substance abuse education has been to conduct an enquiry in nine countries. The goal of this research was to obtain a more detailed picture of the training programmes under way in those countries.

In spite of the limitations of this research (for instance in the problem of a selective response) the results show a rather bleak perspective. To summarize, in only a few countries are fruitful efforts being made to develop standardized training programmes, although in general, the coordination between these programmes is somewhat deficient. For example, it often appeared that there was no information about training programmes within the same region. In several other countries, there are no initiatives at all in this respect. Most training programmes are directed towards alcohol problems and some include full-scale substance abuse training. Only a few programmes are directed exclusively at illicit substances.

After the data for the enquiry had been collected, a few new developments in the area of substance abuse could be observed. For instance, East European countries are increasingly being confronted by illicit drug abuse. In certain countries, the pattern of drug abuse and dependence is changing. On the other hand, there is an increase of consumption of drugs such as cocaine and designer drugs. More importantly, the AIDS epidemic is adding a new dimension to the problem of substance abuse and its influence on national and international drug policy is becoming very significant.

4.1 Austria

Austria faces three kinds of substance abuse problems: alcohol-related problems, (illicit) drug problems and abuse of prescribed drugs. Prevalence, morbidity and mortality figures clearly indicate that substance abuse problems need high priority in health policy. However to date little attention is being given to this. One of the main causes of this situation is the way society perceives problems of illicit drug abuse. The abuse of drugs is predominantly perceived as a phenomenon of social pathology or of deviancy. Control measures and law enforcement are therefore seen as the appropriate approaches. Medical intervention has had no priority in the field of illicit drug abuse or of prescribed psychoactive drugs. This was different for the treatment of alcoholics. Recently there are signs of changes. Today there is a growing opinion that medical professionals should be more involved in the intervention of substance abuse problems. One of the main reasons for this change is attributable to AIDS.

In a comprehensive policy that has to be designed at this point, it will be important to strive for an integration of medical and nonmedical disciplines.

Today in Austria, there is a strong need to develop a policy for training in substance abuse problems. In this policy, resistance to changes in the medical curriculum have to be overcome. The control of information flow by pharmaceutical companies has to be reduced by means of greater government control. Physicians must be informed on a regular basis about the latest illicit and prescribed drugs. Information has to be given about the dependency potential of new prescribed drugs. Several initiatives have been taken to improve this. Plans for the future include the publication of a manual (to be published soon), the integration of courses on medical sociology and psychology in the current curricula, and training in the physician-patient relationship.

4.2 Spain

Spain has had a considerable substance abuse problem for some time. The Spanish Government has designed a strategy for the solution of these problems.

Another development of importance is the creation of a new structure for the training programmes in Spanish universities. More emphasis is placed on greater autonomy and on collaboration between different academic faculties. This development has led to the foundation of new divisions for health sciences, in which medical, pharmacological and psychological departments cooperate.

Recently, a new postgraduate training course on substance abuse problems has been developed at the University of Barcelona. This course is in fact the first extensive training programme in Spain on substance abuse. The training programme is open to physicians, graduate social workers and psychologists. The course consists of a theoretical orientation and a practical training, together lasting about 200 hours. The training facilities are located in specific treatment centres and in centres for public health care.

In Madrid, the psychiatric department is providing specific training on alcohol problems. The Department of Nursing has a separate training course for the treatment of drug dependence, in collaboration with private institutions. In addition, the Department of Public Health and the Regional Government for Madrid organize information-oriented courses for different health professionals, within the context of the national Plan for Drug Abuse.

4.3 Sweden

Sweden introduced prevention programmes for alcohol and drugs a long time ago and has a comprehensive national control policy on substance abuse. In the past few years, substance abuse training programmes for medical students have been introduced as part of a broader approach to prevent and control substance abuse. However, because of the autonomy of the universities, the curricula in the six different university cities are not fully coordinated.

For many years, Sweden has developed a research and clinical tradition in the field of alcoholism at the major universities. A number of special departments for alcohol and drug dependence research has been initiated. The medical training programme consists of eleven terms. The alcohol- and drug-dependence course is given in the ninth term, running parallel with the psychiatry course.

Since a curriculum reform in 1983, a training course is given four times a year at two departments of the Karolinska Institute, Stockholm. These courses last two weeks. In this period, attention is paid to alcohol, illicit drugs, psychoactive medicines and tobacco use. The main emphasis is on alcohol (about 50%). For one week, students are introduced to clinical and ambulatory treatment settings. They are also exposed to self-help groups.

During the examination, all students are tested on their knowledge of substance abuse problems.

At the pre-clinical level, some introductory information on substance abuse problems is given during the basic courses on social medicine and medical psychology. An evaluation study showed that the course increased the interest and involvement of medical students in substance abuse problems.

In Sweden there are also specific training programmes for public health professionals. Those professionals (psychologists and social workers) have the opportunity of participating in certain nonmedical parts of training programmes for physicians. At the postgraduate level, further training on substance abuse problems is given for general practitioners, psychiatrists, gastroenterologists and neurologists.

4.4 USSR

In comparison to other countries, the USSR is hardly faced with illicit drug abuse problems, although alcoholism is a rather serious problem.

In the USSR, a different terminology is used for substance abuse problems. Narcotic drugs are substances appearing in the schedules of the international conventions. The psychoactive substances not indicated in these lists or prescribed by physicians are toxicomanic. Examples of these toxicomanic drugs are tobacco and solvents. Alcohol is a separate entity that is usually included in the category of narcology.

In the training programmes for psychiatrists, attention is given to prevention, diagnosis, counselling and treatment of alcohol abuse. In the pharmacology training programmes (in the clinical pharmacology part) special attention is being given to dependency problems.

Psychiatrists who have received a special training in alcohol problems and narcomania are recognised as "narcologists". Their specialization is based on specific postgraduate training programmes. After the start of the recent alcohol campaign in the USSR, there is more interest in this special training.

In the USSR, there is a special health professional for counselling and support of people with alcohol problems, working in primary health care settings. These professionals are called "feldscher". Feldschers have a central role, especially in outreach treatment programmes. They play a significant role in the early recognition of alcohol problems. People with alcohol problems tend to admit their problems more easily when confronted with a feldscher than they would do when communicating with a physician.

As a rule, drug addicts are treated medically on a voluntary basis.

4.5 Different national substance abuse policies

A first point of difference between the various national policies lies in the attitudes demonstrated towards substance abuse problems. There are differences between national governments and the general public on the one hand and medical and other health professionals on the other.

Part of the explanation is found in the difference in prevalence and epidemiology of substance abuse problems in the countries under review.

In the USSR, an illegal drugs problem hardly exists. On the other hand, a positive change in public awareness and attitudes can be observed as a result of the recently initiated campaign against alcohol. In Spain, however, there is a major drug abuse problem and the government has consequently decided to conduct a national plan to combat drug abuse. In Austria, a gradual change in attitude can be observed. The Government and several experts point to the need for developing a comprehensive approach on substance abuse, both in the areas of alcohol and illicit drugs and of prescribed drugs. Nevertheless, the general public is of course aware of the problem of illicit drug abuse and gives it a high profile. To a lesser degree, it is aware of the dangers of alcoholism but still ignores the problem of prescription drug abuse. Medical doctors in general share this common

ignorance. Recently, some work has been done by concerned journalists to make the public sensitive to the dangers of prescription drug abuse. In Sweden, a comprehensive substance abuse policy has been under development for a longer period.

A second major issue is the question of whose task it is to look after substance abuse and who should actively intervene. In Austria, there has been some resistance among organizations of physicians to include substance abuse prevention in the daily practices of physicians. In Poland and Italy, general practitioners on the whole are not very much interested in drug abuse problems, because there is a general belief that addicts should be treated exclusively by psychiatrists. In Sweden, the present policy is to stimulate medical training programmes on a broad basis, including alcohol, illicit drugs, prescribed drugs and tobacco.

A third difference related to the second issue is the structure of the health care systems. There are health care systems with a dominant clinical orientation as in general hospitals. In other health care systems the focus is much more on primary health care.

There is in practically all countries at present much debate about the role general practitioners (and other primary health care professionals) should play in the intervention in substance abuse problems.

5. Substance abuse education in the United States

In Europe, much can be learned from the very fruitful experiences collected by substance abuse medical education organizations in the United States in the past 17 years.

Around 1970, at several conferences on substance abuse in the United States, it was recognized that there were large gaps in medical education on substance abuse. A major explanation for this situation was the absence of specialized treatment centres linked to medical faculties and university hospitals.

In 1972, with the financial support of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA), the Career Teacher Program was developed. This programme was founded to stimulate medical faculties to include substance abuse training courses in their general medical curricula and to provide salary support for career teachers. The career teachers soon started to prepare and develop curricula on substance abuse, editing educational monographs and other educational materials on several aspects of substance abuse. In 1976, the American Association for Medical Education and Research in Substance Abuse (AMERSA) was founded, to function as a coordinating body and a national network for career teachers.

In the beginning, emphasis was put on undergraduate training programmes and, by 1976, 105 medical schools had included a substance abuse training course in their general medical curriculum covering, on average, about 26 hours. Special postgraduate training programmes were developed, often in cooperation with particular organizations for medical and other health professionals.

Today in the United States, an integrated approach to training programmes has been reached, including research, standard educational materials and evaluation. In the past few years, this policy has resulted in a differentiation of training programmes with changes in the selection of more realistic objectives, course content, and teaching methods on substance abuse education.

Separate training programmes for other nonmedical health professionals such as psychologists, nurses, physician assistants and social workers are being developed. Specific courses for certain medical specialities are in preparation. Special monographs directed at disciplines such as family medicine, internal medicine, paediatrics and psychiatry are available.

After 15 years of wide experience in substance abuse training, AMERSA members have revised their policy and programmes in many ways. Some essential features of today's policy and programmes are:

- flexible training programmes with strong emphasis on skill training, attitude formation and the use of group discussion, clinical problem-solving and real or role-played patient interviews;

- strong emphasis on training programmes for primary care physicians, because they are confronted with substance abuse problems in different phases and with all kinds of symptoms; moreover, primary care physicians have contact with the social environment of the patients;

- much emphasis is put on changing the organizational structure within medical faculties to commit staff, deans and directors to support the training programmes;

- the developing of networks for support by seeking close cooperation with organizations for specific medical specializations, such as paediatrics, family physicians, primary care physicians, etc., and with other nonmedical organizations for health professionals.

6. Objectives of substance abuse training

6.1 Introduction

It is pressing to consider the objectives of substance abuse training, not only in terms of the escalation of the problem, but also the level of resources, the central role of the medical profession and, most recently, the repercussions of drug abuse in relation to AIDS.

While not wishing to minimize the conventional function of opportunistic teaching in medical schools, there is a need to view alcohol and drug abuse as requiring focused teaching, by the coordination of effort over all departments, or integration of teaching by one department.

Sometimes more ingenious programmes have been developed where an individual or group of individuals have a special expertise in the field. Fundamental training cannot simply be left to enthusiasts.

6.2 Barriers

It is important to understand the barriers to training which may exist, and thus the difficulty in allocating more time to the medical curricula.

First, trainers may often be untrained themselves. Thus opportunities for provision of training to the teachers must be developed.

Second, the approach required is multidisciplinary, including a number of nonmedical specialities. Indeed, many treatment skills are those developed by psychologists, and with which medically trained personnel are understandably unfamiliar.

Third, the complexity of influences operating in the substance misuse field may be daunting compared to a relatively more simplistic organic approach.

Fourth, there are misconceptions about the poor long-term outcome of patients with substance abuse problems. These negative views are a further barrier to implementation of training.

In designing a course for medical students, attention must be paid to:

- attitude to change
- development of skills
- transfer of factual knowledge.

6.3 Historical development of ideas about objectives

For many years there has been discussion about the main objective in substance abuse training. In his review, Grant (9) concluded:

> "It suggests that programmes which adopt a strong attitudinal (and clinical) approach stand a very good chance of having a positive impact on those very areas. Since the potentially damaging effects of negative attitudes among doctors are so considerable and are likely to influence both susceptibility to further training and the likelihood of future clinical involvement in alcohol-dependent patients, the importance of this finding is very considerable."

Early on in the development of substance abuse training programmes, much emphasis was placed on factual knowledge covering the following subjects: pharmacology, etiology, epidemiology, diagnosis, prescribing practices, pathology, psychopathology, social complications, basic mechanisms of substance abuse dependence, legal, historical and ethical aspects. Knowledge of these key areas was thought to be necessary before physicians enter clinical practice.

After several studies had indicated that attitudes predominantly influence how students process information on substance abuse, more emphasis was placed on modifying those attitudes.

Later, it was stressed that skill training should be the main focus in substance abuse education: communication, treatment and research skills. The contribution of the discipline of psychology with adjuncts of psychotherapy

and counselling has stimulated interest. Research findings, where the development and design of early intervention techniques in screening and detection (CAGE, MAST and DAST) and implementation of minimal intervention treatment techniques (self-help manuals, WHO publication Drug dependence and alcohol related problems), appeared to be effective. These were applicable to a wide range of health professionals, including primary health professionals.

There is obviously overlap, because gaining knowledge and skills leads to attitude change and positive attitude creates the motivation required for learning skills.

Training thus needs to begin very early on in the pre-clinical stage. Students should be provided during their training with a general overview as to the stages at which they will be exposed to substance abuse problems.

It seems to be important to have positive influence on attitudes at the pre-clinical stage of the medical training, especially so as to prevent attitudes becoming unfavourable during clinical practice.

As long as medical students lack basic knowledge of the many aspects of substance abuse, it is, however, neither very fruitful nor effective to attempt to have positive impact on attitudes. Consequently, during the undergraduate phase, attention has to be paid to both the knowledge element and to the attitude formation. To cite Williams (10): "Positive education on substance abuse must often begin with attitude change."

Medical students should not only be taught about complications of substance abuse dependence. Information also has to be presented on prevention, early diagnosis and the results of successful interventions. Due to different curricula in different countries, the medical students' involvement in practical work and their contact with patients, especially in the early phases of the curriculum, varies considerably. If we recognize prescribing practices as a basic skill and part of the doctor/patient interaction, then the shaping of attitudes in the direction of rational and responsible prescribing behaviour is only possible if the students have experienced some aspects of this particular relationship. Consequently, skill training is probably best taught at graduate level, during the start of clinical practice.

6.4 Essential factual elements

In general it is felt that factual elements should be included in the early phases of substance abuse training programmes.

The following is a list of topics that are to be considered:

- basic definitions and concepts related to substance abuse, such as psychological and physical dependence, abstinence, tolerance, withdrawal symptoms;
- epidemiology of substance abuse, including prevalence, incidence, mortality and morbidity;
- basic sciences: biochemistry, pharmacology, pathology, genetics, physiology;

- sociocultural factors, including family, ethnical, political, social backgrounds;

- psychological factors, including the addictive personality, psychological theories: learning theory, psychodynamic theories, stress-coping mechanisms, self-destructive behaviour;

- diagnosis and early intervention strategies, including early detection, minimal intervention techniques;

- treatment strategies of substance abuse, including treatment of overdose, withdrawal symptoms;

- models of prevention: primary, secondary and tertiary prevention in specific areas and for specific target groups, e.g. industrial programmes, school programmes, fetal substance abuse detection programmes;

- legal, ethical and historical aspects.

In this context, a consensus statement on substance abuse training developed in the United States was discussed in the meeting (11). This document lists in detail the requirements and components of an adequate curriculum. It was felt, however, that imposing a set of detailed objectives and methods would perhaps at this stage be somewhat premature in the European context. It was emphasised that a high degree of flexibility is needed regarding the particular choice of content as well as the methods of training.

The course should be organized to focus not only on facts, but also to introduce students to the variety of approaches, concepts, perspectives and methods involved in gaining an understanding of substance abuse issues.

This should motivate students to read up for themselves, and self-study methods and course books are important. Special attention should be paid to the role of the doctor in society and its relationship to substance abusers, the influence of culture and ethnicity, lifestyle and nutrition, and to changing disease patterns in the community and its association with prevention. Sociological and community medicine departments have a particular role to play in this report.

6.5 Attitude formation

Research literature shows that physicians and medical students often have a very limited conception of their role and task as health professionals. They define their role as an active one and give treatment the highest priority. They often fail to include prevention, counselling and guidance.

Kinney, et al. (12) have indicated that medical students have a mistaken conception of the role of a physician. The physician's first duty is to "cure". They do not believe that physicians should also be involved in care and counselling. Care and counselling are very important in the treatment of substance abuse problems, because counselling, motivation to undergo treatment and after-care (to prevent relapse) need the full attention of the physician. According to Nocks (13), a positive influence on attitudes towards treatment is only useful when the physician or medical student accepts that a medical job not only means "curing" but also "caring".

In addition to this, there is another important aspect related to attitude formation regarding substance abuse. In medical practice, substance abuse problems are often categorized within the group of "chronic diseases" (hypertension, asthma, rheumatism, high blood pressure). Generally, the chances of recovery from these diseases are very low. However, substance abuse problems should not be categorized as chronic diseases because they have a far better prognosis.

An important question is to what extent physicians and other health professionals, who are not specialists in substance abuse, may be expected to intervene in problems of substance abuse in its various stages. Obviously there are limits to his or her intervention, especially when one is faced with people who are seriously addicted. In general, primary health care physicians cannot be expected to deal with all aspects of substance abuse problems, in all phases of addiction or with full-scale treatment and rehabilitation.

As a basic rule, upon completion of a substance abuse training course, medical students might be expected to have acquired the following attitudes:

- positive interest in approaching and maintaining contact with substance-abusing patients;
- persistence in obtaining the information necessary for assessment of patients' substance abuse;
- positive approach to the spectrum of treatment resources and community services, e.g. treatment intervention;
- optimism about treatment outcome.

6.6 Skills training and intervention techniques

Besides the fundamental conditions of sufficient knowledge, insight and favourable attitude, health professionals must be trained in skills directed at prevention, early detection, counselling and treatment.

Skill training has a general and a specific level. In most training programmes, attention is paid to doctor/patient relationships, especially with regard to such problems as responsibility and rules. Interview techniques and dimensions of communications such as counter transfer, double binds and empathy are often included. This general training on skills can be used as a basis for skill training on substance abuse problems.

In skill training directed at teaching doctors how to manage preventive tasks, attention should be paid to the physician's role of "educator", to early detection, to the necessary support of the patient's family and to a rational and responsible prescription of psychotropic substances.

Skill training directed towards the development of skills for counselling and treatment has to deal with the training of diagnostic skills: history taking (medical, social background, personal life development), interventional and motivation techniques, and biomedical and psychosocial treatment strategies. Some of the other key component skills which can be addressed include:

- conducting substance abuse screening
- responding to patient denial, anger, etc.
- explaining medical concerns and possible diagnoses to patient
- providing support and information during rehabilitation to family members.

Due to different curricula in different countries, the medical students' involvement in practical work and their contact with patients, especially in the early phases of the curriculum, varies considerably. Consequently, it remains controversial as to whether clinical skill training is best taught at the clinical level.

A favourable development regarding skill training is the availability of several intervention techniques. These techniques can be used as tools for early detection of substance abuse problems (e.g. MAST, MALT, CAGE, DAST), tools for diagnosis (DSM-III-R), and as tools for counselling and treatment (minimal intervention techniques, self-help manuals, drinking diaries).

7. Methods

The training methods need to be innovative, involving student participation:

- There should be formal training. Lectures, seminars, symposia and the contents should be regularly examined by written, viva and clinical examination.

- Experience gained by clinical exposure should be assessed by case presentations, performance in case conferences, and case-histories on patients. Further examination should take place during clinical and viva examinations.

- Project work and small groups. Students should have an opportunity to visit agencies in the community. Thereafter short reports should be presented for assessment. There should also be opportunities to meet and discuss issues in small groups.

Thus, focus should be on providing students with a range of different teaching settings in which they participate and which are regularly assessed by a variety of methods.

Finally, there may be a case for developing a "core" curriculum which, though flexible, could provide medical school with guidelines for training.

In addition, students could be monitored as they graduate through medical school in order to gauge the impact of training on their attitude to substance abusers.

8. Structural conditions for the implementation of training programmes

The implementation of substance abuse education programmes is to a great extent also dependent upon the position taken by administrators and politicians.

An active drug abuse policy in which a plan has been developed to stimulate a greater awareness of substance abuse problems is available in such

countries as the Netherlands and USSR. Large scale mass media campaigns have been carried out as part of an overall plan. Another example is the National Plan on Drug Abuse in Spain.

Within the health care system itself, we are confronted by some lack of agreement on the responsibilities of the different sectors whose task is it to care for substance abuse problems. A related problem is the status of substance abuse as a specialty or sub-specialty. Recognition of substance abuse treatment as a specialty is exceptional. As a rule, substance abuse treatment is included in the general framework of psychiatry.

An effective mechanism for enhancing the level of education on substance abuse problems is to create a task force of faculty members interested in the subject. Such a group can identify the existing strengths and weaknesses of the curriculum in relation to substance abuse. The task force can explore and test improvements, be it by bringing appropriate material into established courses or by organizing a specific course that addresses substance abuse.

Many universities are changing their curricula in an effort to shorten undergraduate training programmes. Presently in Sweden and the Netherlands, more space in the curriculum is being devoted to substance abuse training. Support has to be given to such developments by creating national and international networks. This strategy has had very good results in the United States. The establishment of an international European network on this subject will further reinforce individual efforts. Substance abuse should also be included in final examinations.

9. Postgraduate training programmes

Several substance abuse training programmes at the postgraduate level are currently being implemented in the region.

In Spain and the United Kingdom, postgraduate programmes take up the whole academic year. The United Kingdom training programme, for example, is a 38-week course with a strong international and multidisciplinary focus. It covers alcohol and drug problems, offers clinical and community placements and integrates teaching on basic sciences with clinical aspects, the design and running of treatment services, prevention and national policy. Although it is primarily intended for medical staff, other professionals with clinical experience, such as nurses and psychologists, are allowed to participate in the course. The English and Spanish courses both aim at yielding addiction specialists, whose primary task is to treat addicts and whose secondary purpose is to train other health professionals. The courses presently being given in the Netherlands and USSR are considerably shorter.

A favourable perspective at the European level lies in the further stimulation of such postgraduate training programmes.

It was felt that postgraduate training courses of limited duration could be expanded. To reduce budgetary costs and to offer practising physicians the opportunity of participating, these courses should not last more than a few days. They should be given on a continuous basis to enable many physicians to participate and to cover recent developments on substance abuse.

10. Recommendations

A number of general recommendations follow. Specific recommendations are then given for undergraduate and postgraduate training programmes. Finally, specific guidelines for the training of general practitioners, specialist physicians, general psychiatrists, and for programmes for disciplines specifically related to substance abuse problems, are outlined, together with recommendations for training of nonmedical health professionals.

10.1 General recommendations

- Substance abuse problems need much attention in medical undergraduate and postgraduate training programmes. They also have to be directed in other, nonmedical, health professional training programmes, e.g. for psychologists, nurses and social workers.

- Education and training on substance abuse problems should not only include pharmacological and strictly medical aspects but also psychological, health, social, ethical and legal problems which are connected to nonmedical use of substances.

- In all programmes, training is needed on preventive aspects.

- On a European level, standardized postgraduate training programmes for health professionals should be the ultimate goal.

- In the official examinations of medical and other health professional training programmes, items on substance abuse should be included.

- In the long term, training expertise on substance abuse has to be acquired, following the "teaching the teachers model".

- At the European level, a focal point should be developed for information and distribution of educational materials on content, objectives and guidelines of training programmes.

- A regional network for cooperation should be established. This would facilitate the exchange experiences and stimulate new initiatives.

- Collaboration from this focal point and this network should be established with nongovernmental organizations with the intention of providing further support for the development of substance abuse education.

- Special attention should be given to substance abuse training for primary health care professionals. In this context more research is required to determine what can be expected, under varying circumstances, of primary health care professionals in managing substance abuse problems.

- Besides developing standard training programmes on substance abuse, the potential of new methods of education and training should be explored, e.g. self-study methods and computer-based education.

- It is suggested that WHO - possibly with some assistance of a focal point - explores the feasibility of:

  - starting an ongoing information process about postgraduate training at the European level;

  - coordinating and distributing teaching methodologies and materials on substance abuse;

  Further, WHO might:

  - stimulate and support the creation in Europe of an association of professionals with an interest in substance abuse education;

  - stimulate any other initiatives leading to the development of international collaboration in the area of substance abuse education.

10.2 Recommendations for undergraduate training programmes for health and medical students and other health professionals

Substance abuse training programmes should be conducted on a continuous basis, as an integral part of the general medical or health curriculum. The following recommendations and principles concerning content and goals of undergraduate training were formulated.

- Implementation of special courses on drug and alcohol dependence is indicated. Possibly this could be implemented through existing courses on psychiatry, general medicine, etc.

- Coordination on this subject within the medical education system must be brought about. Student participation should be emphasized.

10.3 Recommendations for postgraduate training courses

10.3.1 Objectives for the training of general practitioners

In addition to providing formal lecture-oriented teaching, substance abuse education for primary health care physicians could focus on screening and detection, complications of and management of substance abuse problems in the course of exposure to clinical problems on placements. It should be emphasized that medical students should not only be taught about complications of substance abuse dependence, but also prevention and, most important, the results of successful interventions.

The physician's role of educator should be carefully examined.

10.3.2 Objectives for general psychiatrists and other disciplines

Psychiatrists can obviously underline and amplify basic input such as training in counselling, communication, doctor-patient relationship skills (especially the responsibilities and rules guiding this), but these should be emphasized throughout the course. Interview techniques and dimensions of communication such as transfer, double binds and empathy could be included. Specialist input, especially if units specializing in drug and alcohol

problems are available for students' placements, would be a key feature of training. This would enlighten students as to the range of possible treatment options, referral networks, service provision, working in a multidisciplinary team, and, most important, the exciting diversity of experience offered by workers in the field of addiction behaviour.

Particular attention needs to be paid to problems of drug misuse in the elderly, by geriatricians, as it does to the effects of drug and alcohol problems on family and child developments by paediatricians and obstetricians. The difficulties women have in accepting help needs to be examined in this context.

The substance abuse training course should be practically oriented, with a solid theoretical basis. Suggestions for the contents of modules are as follows.

- A section on fundamental scientific approaches to the study of drug addiction should present information on historical, social, psychological and biological perspectives, it should also contain a discussion of philosophical, ethical and anthropological topics.

- Special clinical characteristics of individual drugs of dependence should be illustrated. The physical and psychiatric complications of alcohol and drug abuse, and problems related to special groups, e.g. the pregnant addict, fetal alcohol syndrome, cannabis psychosis and those afflicted with AIDS, should be discussed.

- Training of the special skills in techniques of case assessment should revolve around the individual, the family and the community. While this may include laboratory testing and psychological evaluation, the basic clinical information and case management should be emphasized. Screening and early detection demand subtle application of the clinical skills described above.

- Training in principles of treatment should equip trainees with an understanding of the principles of the therapeutic relationship, therapeutic goals, family, group and individual therapy, self-help groups, therapeutic communities, detoxification and pharmacotherapy. Trainers should have the opportunity to observe professionals at work, to tackle clinical problems and be given ample feedback.

- Organization of treatment services touches on the mobilization of community resources at the primary level of care, the required range of treatment and rehabilitation facilities, and a knowledge of referral systems and support networks.

- Policy on prevention and legal aspects of drug and alcohol problems could explore the control of supply, the organization of the illicit drugs market and the role of the doctor in prescribing psychoactive drugs.

- The development of teaching and management skills will allow trainees to take full responsibility for a training system. This could include giving support to self-help groups, acting in a consultant capacity to colleagues and informing other professionals in associated fields.

10.3.3 Objectives for psychiatrists and those from other disciplines sub-specializing in abuse of psychoactive substances

This group should obtain complete knowledge of theoretical aspects, prevention, diagnosis, treatment, and rehabilitation techniques in the whole area of psychoactive substance abuse, including alcohol. Such a course should be of long duration, providing not only theoretical but also practical skills. It should be completed by an examination, and if possible should result in a degree or a specialist title being conferred.

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Annex 1

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